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Healthcare in the United States

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This article describes the healthcare system in the US, current issues, cost and management.

Healthcare

The US has a mixed system of public and private insurance. Most working-age Americans receive private health insurance through their employers. Private health insurance covers about 70% of the population, but it accounts for only 35% of the healthcare spending (Levit et al. 2004). Over 40 million Americans do not have health insurance and about half of bankruptcies in the US involve a medical reason or large medical debt. Private and government programmes for healthcare exist and are explained below.

Private Programmes

1. Health Maintenance Organizations (HMOs): An HMO is a prepaid “managed” health plan delivering comprehensive care to members through designated providers, having a fixed periodic payment for health services.

2. Preferred Provider Organizations (PPO): A PPO has arrangements with doctors, hospitals and other providers who have agreed to accept the plan’s allowable charges for covered medical services that are similar to a fee-for-service plan. This gives patients a choice of using doctors and hospitals in a network with a co-payment and outside network with an annual deductible and a percent of the bill. More Americans with job-provided insurance are enrolled in PPOs (41%) than in HMOs (29%) (Oberlander 2002).

Government Programmes

1. Medicare: A federal program provides health insurance to all Americans over 65 years of age, persons with disabilities and end-stage renal disease.

2. Medicaid: This health insurance program provides for certain low-income families with children; aged, blind, or disabled people on supplemental security income, certain low-income pregnant women and children, and people who have very high medical bills. Medicaid is funded and administered through a state-federal partnership. Although there are broad federal requirements for Medicaid, states have a wide degree of flexibility to design their program. However all states must cover basic services: inpatient and out patient hospital services, skilled nursing and home health services, family planning, and periodic health check ups. Medicaid reaches about 40% of Americans at the 100% poverty level (defined as an annual income of $9,570 for a family size of one person; Dept of Health and Human Services 2005; US Census Bureau 2006).

3. State Children’s Health Insurance Program (SCHIP): This provides health benefits coverage to children living in families whose income exceeds the eligibility limits for Medicaid with incomes at or below 200%of the federal poverty level (annual income of $32,180 for a family size of 3).

4. There is also a military plan for active and retired servicemen and women.

Healthcare Statistics and Costs

US life expectancy was 77.6 years in 2003 (74.8 for men and 80.1 for women). Deaths from heart disease, cancer and stroke continue to drop (National Centre for Health Statistics 2005). Heart diseases are the number one cause of death followed by malignant neoplasm and cerebrovascular diseases (ibid). Infant mortality has dropped to 6.9 deaths per 1,000 live births.

As a percentage of GDP, healthcare spending reached 15.4% in 2004 (Centres for Medicare and Medicaid Services 2005). In 2005 it is estimated that the total National Health expenditure was $1,921 billion. National healthcare expenditures are projected to reach $3.6 trillion (18.7% of GDP) in 2014, growing at an average annual rate of 7.1% per year from 2003 to 2014 (Centres for Medicare and Medicaid Services 2004 & 2005). Intensive care units spend 10-30% of a hospital budget which accounts for to 0.5-1% of the GDP (Polderman and Metnitz 2005).

The US has the highest per capita health expenditure of any nation (Anderson et al. 2003). It spent $5267 per person for healthcare in 2002, compared to the second most expensive system in Switzerland ($3445 per capita; Bodenhemier 2005). Ten percent of the population accounts for 70% of the cost (Bodenhemier and Fernandez 2005). Figure 1 presents relative healthcare expenditures (Bodenhemier 2005; Levit et al. 2004). Prescription drugs have been the fastest growing expenditure, increasing at a rate of 11% over the last 3 years.

The US had fewer physicians and hospital admissions per 1,000 population, physician visits per capita, acute care beds and acute care days per capita than the median of industrialized countries (Anderson et al. 2003). The medical school enrolment has been con- stant since 1980 in the US, and the increase in number of physicians has mostly come from physicians who immigrated to the US following medical education in other countries (Anderson et al. 2003). In 2000, per 1000 population there were 8.3 nurses, 2.8 physicians, 3 acute care beds, and 118 admissions. There were 5.8 physician visits per capita (ibid).

US Healthcare System: An Analysis

A rapidly emerging trend in every American metropolitan area is the formation of health networks made up of hospitals, physicians and insurance underwriters. Managed care, an organized way to manage the cost, use and quality of the healthcare system has had a profound impact on the delivery of medical services, transforming traditional insurance arrangements (Oberlander 2002). Most studies have found little difference in quality of care between traditional insurers and managed care plans, though there is evidence of worse outcomes for chronically ill seniors in HMOs (Miller and Luft 1997). The functional status of the elderly has improved recently and there is a decreased death rate. Recent advances are cost effective at generally accepted values of an added year of life (Cutler and McClellan 2001).

While rising costs may not create major problems for the economy as a whole, they negatively affect employers, employees, government and patients. The aging population is not an adequate explanation for the increased cost since it is too gradual a process to rank as a major cost driver in healthcare (Reinhardt 2003). The lack of well developed competitive markets in healthcare may be partially responsible for the higher expenditure. Technologies such as magnetic resonance imaging, computed tomography, coronary artery bypass graft, angioplasty, intensive care units, positron emission tomography and radiation oncology facilities are associated with higher costs and are used extensively in the US (Bodenheimer 2005). However, Japan's healthcare system has the highest usage of CT and MRI scanners (84.4 and 23.2 compared to the USA's 13.6 and 8.1 per million population in 2000) and a relatively high use of dialysis, with the least expensive health system among developed countries (Anderson et al. 2003).

The US also has the highest cost per unit of care, physician fees, payment per hospital day and pharmaceutical prices. Even though physician visits and hospital days per capita have been lower in the US than many other developed nations, use of expensive technologies, market power of hospitals and physicians, who are able to garner high prices for services, more rapid diffusion of innovative technologies, and a high- er cost for administering the healthcare system has driven the overall healthcare cost to be high (Bodenheimer 2005). One proposed driver of healthcare spending growth is the medical malpractice system, which encourages physicians to practice "defensive medicine" by ordering unnecessary diagnostic tests or treatments to avoid malpractice litigation (Anderson 1999). Defensive medicine may account for 5-9% of health expenditure (Hessler and McClellan 1996).

Approximately 63% of growth in healthcare spending is the result of an increased prevalence of obesity, stress, ozone, changing treatment threshold for hypertension, diabetes, hyperlipidaemia and osteoporosis and new innovations like statins, antidepressants, and other medications (Thorpe et al. 2005). Treatment of low-birth weight babies and heart attacks has also accounted for 37% of growth in healthcare spending (ibid).

One strategy for reducing the growth in healthcare costs is to focus on slowing or reversing prevalence of obesity including school based interventions to reduce childhood obesity (15% of school-age children were obese in 2000), changing certain behaviours like smoking and driving while intoxicated, work place health promotion programmes, and cost effective use of high cost, low benefit medical technologies.

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